# Citizens Ambulance Service Patient Transport Form

**Patient Name:** _____ **DOB:** _____ **Transport Date:** _____

**Privacy Practices Acknowledgment:** by signing below, the signer acknowledges that **Citizens Ambulance Service** provided a copy of its Notice of Privacy Practices to the patient or other party with instructions to provide the Notice to the patient. ***A copy of this form is valid as an original***

## SECTION I - PATIENT SIGNATURE

**The patient must sign here unless the patient is physically or mentally incapable of signing.**
**NOTE: If the patient is a minor, the parent or legal guardian should sign in this section.**

I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by **Citizens Ambulance Service** now, in the past, or in the future, until I revoke this authorization in writing. I understand that I am financially responsible for the services and supplies provided to me by **Citizens Ambulance Service** regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to what was paid by my insurance. I agree to immediately remit to **Citizens Ambulance Service** any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to **Citizens Ambulance Service.** I authorize **Citizens Ambulance Service** to appeal payment denials or other adverse decisions on my behalf. I authorize and direct any holder of medical, insurance, billing or other relevant information about me to release such information to **Citizens Ambulance Service** and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payers or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by **Citizens Ambulance Service**, now, in the past, or in the future. I also authorize **Citizens Ambulance Service** to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information.

X_____ _____ _____
**Patient** (or Parent) **Signature or Mark** **Date** Parent / Guardian Name

X_____ _____ _____ _____
**Witness Signature** **Date** Parent / Guardian DOB Parent / Guardian Phone

X_____ _____
**Witness Name and Title** Parent / Guardian SSN

## SECTION II - AUTHORIZED REPRESENTATIVE SIGNATURE

Complete this section **only** if the patient is physically or mentally incapable of signing.

**Describe the circumstances that make it impractical for the patient to sign:** _____

I am signing on behalf of the patient to authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by **Citizens Ambulance Service** now or in the past or in the future. By signing below, I acknowledge that I am one of the authorized signers listed below. **My signature is not an acceptance of financial responsibility for the services rendered.**

Authorized representatives include **only** the following individuals:

- ☐ Patient's legal guardian (for patients under the age of 18, use Section I above)
- ☐ Relative or other person who receives social security or other governmental benefits on behalf of the patient
- ☐ Relative or other person who arranges for the patient's treatment or exercises other responsibility for the patient's affairs
- ☐ Representative of an agency or institution that did not furnish the services for which payment is claimed (i.e., ambulance services) but furnished other care, services, or assistance to the patient

X_____ _____ _____
**Representative Signature** **Date** **Printed Name of Representative**

## SECTION III - AMBULANCE CREW AND RECEIVING FACILITY SIGNATURES

Complete this section **only** if: (1) the patient was physically or mentally incapable of signing, **and**
(2) no authorized representative (Section II) was available or willing to sign on behalf of the patient at the time of service.

**Describe the circumstances that make it impractical for the patient to sign:** _____

Name and Location of Receiving Facility: _____ Time: _____

A signature below authorizes submission of a claim to Medicare, Medicaid, or any other payer for any services provided to the patient by **Citizens Ambulance Service.**

**A. Ambulance Crew Member Statement (*must* be completed by crew member at time of transport)**
My signature below indicates that, at the time of service, the patient was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were available or willing to sign on the patient's behalf. **My signature is not an acceptance of financial responsibility for the services rendered.**

X_____ _____ _____
Signature of Crewmember Date Printed Name and Title of Crewmember

**B. Receiving Facility Representative Signature**
The patient named on this form was received by this facility on the date and at the time indicated and this facility furnished care, services or assistance to the patient. **My signature is not an acceptance of financial responsibility for the services rendered.**

X_____ _____ _____
Signature of Receiving Facility Representative Date Printed Name and Title of Receiving Facility Representative

# Citizens Ambulance Service Patient Refusal Form

Date: _____/_____/20_____ Patient Name: _____

DOB: _____/_____/_____ Phone #: (_____) _____-_____ SSN: _____-_____-_____

FULL Address: _____

Parent / Guardian Name: _____ Parent / Guardian DOB: _____/_____/_____

Parent / Guardian Phone: (_____) _____-_____ Parent / Guardian SSN: _____-_____-_____

**Suspected serious injury or illness** based upon patient history, mechanism of injury, or physical examination? □Yes □No

Situation of Injury/Illness: _____

**18 years of age or older?** □Yes □No

**Any evidence of:** Suicide attempt? □Yes □No Head injury? □Yes □No

**Patient Oriented to:**

**Person** □Yes □No **Place** □Yes □No **Time** □Yes □No **Event** □Yes □No

**Syncope?** □Yes □No **Intoxication?** □Yes □No **Chest Pain?** □Yes □No **Dyspnea?** □Yes □No

**Vital Signs**

Pulse: _____ BP: _____ / _____ Resp: _____ SpO2: _____% Glucose: _____mg/dl

Risks explained to patient: □Yes □No
Patient understands clinical situation: □Yes □No
Patient verbalizes understanding of risks: □Yes □No
Patient plans to seek further medical evaluation: □Yes □No

**Patient Outcome**

□ Patient **refused EMS assessment**
□ Patient **refused transport** to a hospital against EMS advice
□ Patient **refused transport** to EMS crew recommended hospital
□ Patient accepts transportation to hospital by EMS but **refuses any or all treatment offered**
Specify: _____
□ Patient **refused C – Spine Precautions**
□ Other: _____

This form is being provided to me because I have refused assessment, treatment and/or transport by an EMS provider for myself or on behalf of the patient list above. I understand the EMS providers are not physicians and are not qualified or authorized to make a diagnosis and that their care is not a substitute for that of a physician. I recognize that there may be a serious injury or illness which could get worse without medical attention even though I (or the patient) may feel fine at the present time. I understand that I (or the patient) may change my mind, call 911, and/or seek treatment or assistance later. I also understand that treatment is available at an emergency department 24 hours a day. I acknowledge that this advice has been explained to me by the EMS crew and that I have read this form completely and understand its terms.

I authorize the submission of a claim to Medicare, Medicaid, or any other payer for any services provided to me by Citizens Ambulance Service now, in the past, or in the future, until I revoke this authorization in writing. I understand that I am financially responsible for the services and supplies provided to me by Citizens Ambulance Service regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to what was paid by my insurance. I agree to immediately remit to Citizens Ambulance Service any payments that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to Citizens Ambulance Service. I authorize Citizens Ambulance Service to appeal payment denials or other adverse decisions on my behalf. I authorize and direct any holder of medical, insurance, billing or other relevant information about me to release such information to Citizens Ambulance Service and its billing agents, the Centers for Medicare and Medicaid Services, and/or any other payers or insurers, and their respective agents or contractors, as may be necessary to determine these or other benefits payable for any services provided to me by Citizens Ambulance Service, now, in the past, or in the future. I also authorize Citizens Ambulance Service to obtain medical, insurance, billing and other relevant information about me from any party, database or other source that maintains such information.

_____ _____

**Signature (Patient or Other)** **EMS Provider Signature**

_____ _____

If other than patient, print name and relationship to patient **Witness Signature**